State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Ms. Linda Minamoto
Associate Regional Administrator
Division of Medicaid and Children's Health
Department of Health and Human Services
Centers for Medicare and Medicaid Services
75 Hawthorne Street, Fourth Floor
San Francisco, CA 94105-3903

D R A F T May 31, 2005
Subject to change

Dear Ms. Minamoto:

STATE PLAN AMENDMENT 05-005:

This is in response to your letter dated May 2, 2005, requesting additional information regarding the Department of Health Services (DHS) submission of an amendment for a new Supplement 4 to Attachment 4.19-D of its State Medicaid Plan submitted to the Centers for Medicare & Medicaid Services (CMS) on February 1, 2005, under transmittal number (TN) 04-012. This supplement describes the methods and standards for establishing facility-specific reimbursement rates for freestanding skilled nursing facilities level-B (NF-B) and subacute care units of freestanding NF-B's. This supplement is prompted by new facility-specific rate methodology mandated by state legislation, Assembly Bill 1629 (Statutes of 2004, Chapter 875).

The following responds to the specific requests (in bold) for additional information. Enclosures are numbered to coincide with the number of the related question. Also provided is a summary list of those enclosures.

Questions and Responses Regarding State Plan Amendment (SPA) Language

1. **How is this rate increase funded? If it is based solely on the increase in the provider quality assessment, please describe the impact of the rate increase under this SPA on providers, by individual facility, affected by the tax and the reimbursement change**.

   The rate increase is funded through Federal Financial Participation (FFP) and State General Fund (GF). The increase in GF expenditures is partially funded by

1501 Capitol Avenue, Suite 71.6086, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
(916) 440-7800 Fax (916) 440-7805
www.dhs.ca.gov

the provider quality assurance fee (QAF) which is deposited in the State GF. For the proposed new methodology, our calculations show the following:

- **Rate Increase Calculations**

Fiscal Year (FY) 2004-05 Total Medi-Cal Payments (without QAF add-on): $2,870,601,842

FY 2005-06 Total Medi-Cal Payments (without QAF add-on): $3,100,249,989

Increased Expenditures Resulting from the New Rate Methodology (from FY 2004-05 to FY 2005-06): $229,648,147 Total Funds (TF)

Percentage Increase To Rates (from FY 2004-05 to FY 2005-06): 8.0 Percent
($3,100,249,989 / $2,870,601,842) - 1 = 8%)

- **QAF Calculations**

QAF Collected Based on 6% of Total Net Revenue: $241,017,728

State share of the portion of the total rate increase attributable to reimbursement of the QAF: $ 83,473,675 GF

Total General Fund retained from the QAF: $157,544,053

These calculations demonstrate that the increased funds collected from the QAF will more than cover the state share (which is $198.3 million) of the total rate increase in FY 2005-06. As a result, $42.7 million of the QAF as collected will remain in the GF. In future years, the GF impact of the new methodology will exceed revenue from the QAF.

- **Impact of SPA on Facilities**

When the QAF (as paid and reimbursed) is combined with the rate increase due to the new rate methodology, 133 facilities will lose (ranging from $314 to $384,526), and 891 facilities will experience a gain (ranging from $1,346 to $775,883). Of those 891 facilities, three facilities reported entirely Medi-Cal days. These three facilities will gain solely from the rate methodology, but will only break-even when the impact of the QAF is also considered. In SFY 2005-06, for all 1,024 facilities in the aggregate, there will be a net gain of $154,117,748 TF when both the QAF (as paid and reimbursed) and the rate methodology increases are considered.

The last sheet in the Waiver Calculation file submitted to CMS shows the impact of the QAF by individual facility. The correlation test was performed to determine

if a bias exists between the QAF and the Medicaid days, and found that no bias existed. The Pearson's correlation coefficient for the relationship between the facility's Gain/Loss from the QAF and their respective Medicaid days was only 0.00546. This calculation demonstrates no correlation existed between the facility Gain/Loss from the QAF and Medicaid days. The result of this test is shown in the first sheet in the Waiver Calculation file. A copy of this file is enclosed.

2. **This SPA only addresses the per diem rate methodology for freestanding level-B nursing facilities and sub-acute facilities, are these facilities still able to access supplemental payments under Attachment 4.19-D? If so, how will the supplements be funded.**

   Freestanding NF-Bs do not have access to the supplemental payments outlined in Attachment 4.19-D, Sections VI and VIII. These Sections of the State Plan Attachment 4.19-D apply only to the Distinct Part/Nursing Facilities (DP/NF) of a general acute care hospital. This SPA (Supplement 4 to Attachment 4.19-D) applies to only freestanding NF-B's and subacute units of a freestanding NF-Bs.

3. **Block 1 on Form 179. This SPA is numbered as 04-012, however, it was received in 2005 and the numbering should be changed to reflect the correct year.**

   Form 179 has been amended to SPA number 05-005, to reflect the current year. [See Form 179 enclosed.]

4. **Block 7 on Form 179. Please provide an estimate of the federal budget impact for this SPA. Analysis of the legislation indicates that the federal fiscal impact would be approximately $111,366,000 in FY 05 and $276,741,500 in FY 06.**

   The estimated costs for this SPA for FFY 2005 are $124,206,000 in Federal Funds (FF). The estimated costs for this SPA for FFY 2006 are $297,101,500 FF. These costs are the estimated federal fund increase due to the new rate methodology. [See Form 179 enclosed.]

5. **Block 9 on Form 179. Please clarify the page numbers of the superseded pages relative to this SPA.**

   This SPA does not supersede any part of Attachment 4.19-D. However, page 1 of Attachment 4.19-D was amended to reference the new facility-specific rate methodology. Page 1.1 is the remaining page 1 text. State Plan pages 1-22 labeled Attachment 4.19-D should remain intact for reimbursement policies for provider categories not included in the AB 1629 facility-specific rate methodology. Block 9 on Form 179 is correct. [See Form 179 enclosed.]

6. **Please provide documentation that Public Notice was given as required by 42 CFR 447.205.**

The Public Notice is provided and labeled as Enclosure 6-A.

7. **Preliminary analysis of this rate increase shows a significant fiscal impact. Please provide a demonstration of the upper payment limit in accordance with 42 CFR 447.272, including methodology and facility specific payment information, to show that this payment increase is in compliance with federal regulations. Please include information regarding the new costs (outlined on in Supplement 4, V.C) included in the rates, how they are treated under Medicare payment principles and any adjustments necessary to account for these costs.**

To demonstrate compliance with 42 CFR 447.272, facilities were divided into three groups to perform the Upper Payment Limit (UPL) test: state-owned facilities, non-state government-owned facilities, and privately owned and operated facilities. For each UPL group, estimated Medi-Cal payments under the proposed reimbursement methodology, plus Medi-Cal nursing facility residents' ancillary costs that are included in the Medicare reimbursement rate, were compared to an estimate of reimbursement under the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). Enclosures 7-A, 7-B, and 7-C demonstrate that the reimbursement methodology outlined in SPA 05-005 complies with the upper payment limit requirements in 42 CFR 447.272. A narrative summary of the methodology used to determine compliance with 42 CFR 447.272 follows.

<u>Step 1: Calculate a Weighted-Average Medi-Cal Rate by UPL Group</u>

The methodology used to estimate Medi-Cal payments is a conservative approach, based on a maximum weighted average payment rate, rather than computing a payment estimate using facility-specific costs. Section 14126.033(a)(2)(A) of the Welfare & Institutions Code limits the maximum annual increase in the 2005-06 weighted average Medi-Cal rate to eight percent of the weighted average Medi-Cal reimbursement rate for the 2004-05 rate year, adjusted for the change in the cost to the facility to comply with the nursing facility QAF for the 2005-06 rate year. Because this formula represents the maximum total program reimbursement, this conservative approach was used to ensure the new reimbursement methodology does not result in payments that exceed the SNF PPS methodology.

Each facility's peer group classification under the existing methodology was used to identify the reimbursement rate for the 2004-05 rate period. On a facility-specific basis, the current methodology reimbursement rate was multiplied by the facility's total annualized Medi-Cal skilled nursing days to determine facility-specific Medi-Cal payments. The sum of all facilities' annualized Medi-Cal days,

divided by the sum of all facility-specific Medi-Cal payments establishes a weighted average Medi-Cal reimbursement rate for each of the three UPL groups.

Step 2: Calculate Maximum Medi-Cal Payments under AB1629 Methodology

As noted, the weighted average Medi-Cal rate for the 2004-05 rate year is capped at an eight percent growth rate in the AB1629 legislation. By applying the eight percent cap to the weighted average reimbursement rate, the maximum weighted average rate resulting from the new reimbursement methodology can be calculated. This amount is then multiplied by the number of total paid days for the facilities in the UPL group to estimate total maximum Medi-Cal payments for the new methodology. Paid days per UPL group were obtained from the paid claims data.

Step 3: Incorporating Estimated Quality Assurance Fees and Ancillary Costs

The Medi-Cal portion of the QAF must be incorporated into estimated Medi-Cal payments for the 2005-06 rate year. Accordingly, an estimate of this pass-through cost was calculated for each facility, and the overall sum was added to the subtotal from Step 2. The Medi-Cal portion of the QAF was estimated by multiplying each facility's quality assurance rate ($7.33 for facilities with less than 100,000 total days; $6.33 for facilities with greater than 100,000 total days) by its total annualized Medi-Cal days. Facilities exempt from the QAF are the continuing care retirement communities, multi-level retirement facilities, distinct part/nursing facilities in a general acute care hospital, and facilities operated by the State or another public entity.

Finally, the total amount paid for pharmacy, therapies, laboratory and radiology ancillary services that were provided to Medi-Cal skilled nursing facility residents was added to the subtotal. Ancillary costs by UPL group were identified from the paid claims data.

The product of all preceding calculations represents the total estimated Medi-Cal payments for 2005-06.

Step 4: Estimating the SNF PPS Cost for Medi-Cal Beneficiaries

The total estimated Medicare payments were calculated by running approximately 85,000 MDS assessments through the CMS Grouper software program (M3PI Processor--Version 5.12B). Each MDS assessment was assigned a Resource Utilization Group (RUG) score and linked to the OSHPD cost report dataset to determine the facility county and "urban" or "rural" classification. Wage indices and SNF PPS payment rates for federal fiscal year 2004-05 were obtained from the Federal Register and used to wage-index adjust the labor portion of the Federal rate. Next, facilities were linked to the paid

claims data set by beneficiary SSN to determine a weighted average RUG rate by facility. The technical process of linking the MDS assessments, the OSHPD cost report data, and the paid claims data resulted in a portion of paid claims days for beneficiaries that could not be matched to a specific facility. These "unmatched" days were multiplied by the weighted average payment rate for the respective UPL group, resulting in a total payment estimate based on the SNF PPS methodology for Medi-Cal beneficiaries.

Step 5: Compare the Estimated Maximum Medi-Cal Payments to the Estimated Medicare Payments for Medi-Cal Beneficiaries

To demonstrate compliance with 42 CFR 447.272, estimated payments under the new methodology, plus the cost of ancillaries reimbursable under the SNF PPS, were compared to the estimated payments for Medi-Cal beneficiaries under the SNF PPS. As illustrated in enclosures 7-A, 7-B and 7-C, the State demonstrates compliance with the UPL test.

Each facility will be subjected to a full scope field audit a minimum of once every three years that will establish that costs, except for capital costs reported under the FRVS, have been reported in accordance with Medicare Reimbursement Principles as specified in Title 42, Code of Federal Regulations, Part 413. When it is determined that the elements are not in accordance with those Principles, costs will be adjusted by DHS to comply. Capital costs are not being reimbursed based on facility's costs, therefore review of those related expenses will be limited in scope.

8. **Please provide a copy of the Office of Statewide Health Planning and Development's (OSHPD) reporting form and instructions. Please include and current and/or new supplemental costs reporting formats that are referenced in 04-012 as "supplemental cost reports". If the OSHPD is a total cost survey completed by the hospitals, please explain why these costs were not captured. Specifically, please indicate where the following costs are located in the current OSHPD form and how the form will be adjusted to accommodate specific lines for these costs:**
   a. **Labor costs: 1) direct resident labor costs, 2) indirect care labor, 3) labor-driven operating allocation.**
   b. **Indirect care non-labor**
   c. **Administrative costs**
   d. **Capital costs**
   e. **Direct pass-through costs**

OSHPD reports are a complete cost survey, but are not designed to capture each item required to compute the facility-specific reimbursement system mandated by AB1629. A copy of the OSHPD reporting form and instructions can

be obtained from OSHPD's website at: http://www.oshpd.ca.gov/HID/ltc/finance/manuals/index.htm, Chapter 4000, Reporting Requirements and Instructions. The Reports and Instructions are enclosed on a diskette labeled Enclosure 8-A.

Cost data used to develop reimbursement rates according to the cost categories specified in Supplement 4, IV.C. will be obtained from the facility's OSHPD Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report (OSHPD Report) or the most recent facility-specific Audit Report. The facility-specific Audit Report is the product of DHS' Audits and Investigations program, and is based on the information contained in the OSHPD Report. In instances where data elements are not specifically identifiable from either of these sources, supplemental schedules will be used to augment cost information. For example, medical records costs are currently embedded in the "Administration" line (line 165) of the OSHPD Report, along with many other costs. Since AB 1629 identifies these costs as reimbursable under the Indirect Care Labor cost category, Supplemental Schedule 1 will be used to separate medical records expenditures from the Administrative cost category and reclassify them into the Indirect Care Labor cost category.

In summary, DHS has required two supplemental schedules to identify costs that are currently not visible on the OSHPD Report for the upcoming 2005-06 rate year. The supplemental schedules and accompanying instructions are enclosed on a diskette labeled 8-B.

A crosswalk between the specific OSHPD Report data elements and the cost groupings specified in Supplement 4, V.C. is included as Enclosure 8-C.

Specific Questions

9. **Page 1, Supplement 4, I. F. This provision specifically indicates reimbursement to include, "projected proportional costs for new state or federal mandates for the applicable rates years." What are these mandates specifically and what portion of the fiscal impact are they responsible for?**

For SFY 2005-06, the only costs reflected for new state or federal mandates are those for the QAF. In future periods, new state and federal mandates may be additional costs due to changes occurring since submission of the cost report period. An example of this could be legislatively mandated wage increase when the costs are not included on the submitted cost report.

During FY 2005-06, DHS expects to reimburse the facilities $166,947,351 TF for their costs associated with payment of the QAF. These costs are approximately five percent of the estimated costs of $3,267,197,340 TF.

10. **Page 3, Supplement 4, III. E and G. These provisions allow for supplemental cost schedules to be included in the rate development and also allow for more than 12 months of information to be used in calculating the rate. If the rate is set annually on historic costs, will the supplements be based on more current costs or will they be an estimate of costs not included in the period used to set the rates? Will the supplemental costs be subject to trending? What is the process the state will follow to combine filed costs reports with supplemental (and subsequently filed) cost schedules to determine a final rate? Please include the framework for utilizing filed and supplemental costs schedules in determining the final rates.**

As mentioned previously, the OSHPD reports do not single-out all of the information needed to compute the facility-specific rates. Caregiver Training Costs, Liability Insurance and Facility Licensing fees must be removed from the administration cost center. Medical records costs must also be separately identified. Supplemental schedules will be used to accumulate this information. Therefore, supplemental reports are to report information related to the same fiscal period as the OSHPD report used to annually update the facility-specific rates.

Pass-through costs, obtained from supplemental reports, will be trended in a manner similar to the costs contained in the OSHPD report. Section V.C.5.e, f, and g have been amended to identify treatment of the pass-through costs. [See pages 14-15 of the SPA.]

11. **Page 4, Supplement 4, IV.C. The language specifies that rates are set annually based on audited or reviewed cost data. C.1. further explains that costs reports will be used to determine any difference between "expenditures" in the rate year and costs used to set the rates. Is this a cost reconciliation process? Is there a threshold or minimum dollar amount that would trigger an adjustment to the rates for prospective years? C.2. indicates that, "The amount a cost category is adjusted will be determined by an error factor that reflects a ratio of the difference between the reported costs and the audited expenditures for each cost category." Please explain how this mechanism will work.**

The process described is not a cost reconciliation process. No threshold or minimum dollar amount triggers a prospective rate adjustment to the facility-specific rate. During an audit, when a difference is found between the reported costs and the audited expenditures, that amount is calculated as a percentage called an error factor. That percentage, by cost-grouping, is applied to the facility's reported costs prospectively over the intervening years between audits. To demonstrate how the audit adjustment is applied, if the reported labor costs were $100, but the audit accounts for only $99, a one percent adjustment is made to the labor costs used to calculated the facility-specific rate during the next rate setting cycle.

12. **Page 5, Supplement 4, IV. D. This language says the state "may" change a rate based on incorrectly reported labor costs. The language needs to definitively explain that the state "will" modify the rate as it does in IV, C.2. regarding errors.**

This paragraph involves labor data identified during the audit which are found to be different from that reported on the cost report. In cases where a facility-specific error factor is calculated, that error factor will be used to prospectively adjust the facility-specific reimbursement rate. DHS may exclude those data from computation of the annual labor study, when error factors are identified after completion of the annual study. The SPA language has been amended to reflect that the rates will be adjusted prospectively, but that data may be excluded from computation of the labor index. [See page 5 of the SPA.]

13. **Page 6, Supplement 4, V.C.1.a.ii, b.iii, 2.b, 3.b, and 5d all indicate that an "inflation factor," will be applied to inflate a cost to the current rate year. The state must indicate the factor or the source for the factor.**

The source referred to in Section V.C.1.a.ii. and b.iii., is the labor index, which is the study developed from the most recent historical data in the long-term care industry as reported by providers to OSHPD. This is the same labor index referenced in State Plan Attachment 4.19-D, page 12, D.2. The SPA language was amended to show the labor index. [See pages 7-8 of the SPA.]

The source referred to Section V.C.2.b. and 3.b. is the California Consumer Price Index published by the California Department of Finance. The SPA language was amended to show the California Consumer Price Index. [See pages 8-9 of the SPA.]

The source referred to in Section V.C.5.d. is the property tax index, which is based on Article XIII A of the California State Constitution governing California Property Taxes. That Article limits property taxes to increase by 2 percent annually. The SPA language was amended to show the property tax index. [See pages 15 of the SPA.]

14. **Page 9, Supplement 4, V.C.4a. This section introduces the use of a fair rental value system to determine capital expenses. Section 4a. indicates a "methodology" but does not provide a formula for this methodology to determine a dollar value for this portion of the rate. Instead, the language says that, "the FRVS methodology will be based on formulas developed by the Department that estimate facility value based on a variety of factors…."The state must provide a definitive formula that a facility may use to determine this portion of their rate that identifies all factors used to determine a value and that a facility may calculate based on the information provided in the plan.**

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

15. **Page 9, Supplement 4, V.C.4b. The language must identify what data and factors will be used in the FRVS payment portion of the rate. The current language is not specific enough to meet the requirements of comprehensiveness.**

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

16. **Page 9, 10, Supplement 4, V.C.4c. The language in this section does not specify how a facility's age is determined and how that component would affect the FRVS. The state must include a distinct formula, including derivation of facility age and specific valuations for capital improvements. Please explain how a facility determines "future capital improvements" and the effect on facility age valuations.**

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

17. **Page 10, Supplement 4, V.C.4d. The state must determine a specific source for the value of new construction. The current language indicates two options but must indicate the actual source that will be used. The plan language must also provide the value or effect of "geographic location factors" that are used to "adjust" building value. Again, the language must be specific in the source data used to index base year values, not simply provide an array of potential references.**

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

18. **Page 10, Supplement 4, V.C.4g. This appears to be the methodology the state will follow to create a FRVS component of the facility rate. This formula does not meet the requirements of being comprehensive on its own or in conjunction with the preceding sections as enumerated in questions 14 through 18. The state must provide a formula that a facility may use to determine its FRVS from the state plan.**

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

19. **Page 12, Supplement 4, V.D. The formulas and definitions used to set the payment rates must be included in the state plan but can also be**

enumerated through provider bulletins and state regulations. Please modify language.

The SPA language has been amended to show these changes. [See pages 9-14 of the SPA.]

20. **Page 13, Supplement 4, VII. Please describe how the state will create and apply the geographic peer groupings to meet the requirements of comprehensiveness. The current language simply states that "central tendency measurements" will be used to form geographic peer groups. How will a facility know what its peer group is? What qualifies as a minimal cost variation that would indicate a state-wide peer group? Please clarify the state plan language.**

The SPA language has been amended to describe the peer grouping methodology in greater detail. In addition, the SPA language refers to the DHS website that maintains the Peer Grouping Report that was used to develop the groups. The methodology was based on a statistical analysis that included clustering algorithms. The clustering technique was applied to the median freestanding facility direct labor cost of each county's facilities. The resulting seven county clusters (peer groups) include four "rural" and three "urban" peer groups. As referenced in the amended SPA language, the list of counties assigned to each peer group, as well as the statistical methodology is detailed in the Report at the following website http://www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm.
As an alternative to the website, the report may be requested by writing or calling the Department. The SPA has been amended to show this address and phone information. [See pages 16-17 of the SPA.]

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of your State plan, including payments made outside of those being proposed with this SPA. These questions were asked in regards to previous SPAs. Please provide updated answers including information regarding the proposed tax funding this rate change.

21. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments under TN 04-012 and other methodologies in Attachment 4.19-D including the Federal and State share (includes normal per diem, DRG, DSH, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If these providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a**

complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

The State does not require that providers return any portion of those payments to the State, to any local governmental entity, or to any intermediary organization, once the payments have been made.

22. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, DSH, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).**

The State's share does not use IGTs, or CPEs to fund these services. The State share of payments for these services is funded through the State General Fund, including the funds collected from the QAF. See the response to Question 1 above.

23. **Section 1902(a)(3) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

There are no supplemental payments paid to the providers.

24. **Does any public provider receive payments that in the aggregate under Attachment 4.19-D (normal per diem, DRG, DSH, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

AB 1629's hold harmless provision (Welfare & Institutions Code § 14126.023(e)) requires that facility-specific rates for FYs 2005-06 and 2006-07 may not be less than the rates in effect as of July 31, 2005. To the best of DHS' knowledge, no public provider that operates a nursing facility subject to AB 1629 will receive payments under SPA 05-005 that in the aggregate exceed its reasonable costs of providing services. Our review of those public providers showed that all have costs that are either at or above the median under the current rate methodology (to which the "hold harmless" provision is tied). Thus, there would be no payments to public providers under the current system or the proposed system that would be over-cost.

If you have any questions, please contact Mr. Roberto B. Martinez, Chief of the Medi-Cal Policy Division, at (916) 552-9400.

Sincerely,

Stan Rosenstein
Deputy Director
Medical Care Services

Enclosures

cc: Mr. Roberto B. Martinez, Chief
Medi-Cal Policy Division
Department of Health Services
1501 Capitol Avenue, Suite 71.4001
MS 4600
P.O. Box 997417
Sacramento, CA 95899-7417

Diana Ducay, Chief
Audits & Investigations
Department of Health Services
1501 Capitol Avenue, Suite 71.6070
MS 2000
P.P. Box 997417
Sacramento, CA 95899-7417